



**Please Support The Amended Version of House Bill 16**

1. **Decades of legal precedent ensure HB 16 will only be used to provide emergency detentions for persons in danger of serious physical harm because they have symptoms of mental illness that prevent them from meeting their essential needs of health or safety.**

The recommended change in Montana's "Emergency Detention" standard fit firmly within existing Constitutional law on civil commitments. This law is based upon the United State Supreme Court's holding in *O'Connor v. Donaldson* that a "State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. *O'Connor v. Donaldson*, 422 U.S. 563, 576, 95 S.Ct. 2486, 2494 (1975).

Montana has a basic needs commitment standards in Section 53-21-126(4), but Montana's courts have not developed a significant amount of case law on specifics of that standard. However, basic needs commitment standards have been well litigated for decades in other states and those cases are instructive in the direction that the Montana Supreme Court will likely interpret this statute.

- A. Washington - The Supreme Court of Washington determined that a State seeking to commit someone under an basic needs standard "must present recent, tangible evidence of failure or inability to provide for such essential human needs as food, clothing, shelter, and medical treatment which presents a high probability of serious physical harm within the near future unless adequate treatment is afforded. Furthermore, the failure or inability to provide for these essential needs must be shown to arise as a result of mental disorder and not because of other factors." *In re Labelle*, 107 Wn.2d 196; 728 P.2d 138 (1986).
- B. Oregon - The Oregon Court of Appeals recently made an in-depth description of their basic needs civil commitment process in *State vs. D.M.*, 245 Or.App. 466 (2011). In order to commit a person on the ground that the person is unable to provide for his or her basic needs, the state must prove, by clear and convincing evidence, that, because of a mental disorder, the person is unable to secure basic self-care, and, as a result, the person "probably would not survive in the near future." *State v. Bunting*, 112 Or.App. 143, 146, 826 P.2d 1060 (1992). 78 A person's ability to provide for his or her basic needs is assessed at the time of the commitment hearing " 'in the light of existing, as opposed to future or potential, conditions.' " *State v. C. A. J.*, 230 Or.App. 224, 231 n.5, 213 P.3d 1279 (2009) (*quoting State v. Headings*, 140 Or.App. 421, 426, 914 P.2d 1129

(1996)). A "basic needs" commitment must be based on "more than evidence of speculative threats to safe survival." *A. M.-M.*, 236 Or.App. at 605, 238 P.3d 407. The Oregon Court of Appeals has specifically held that evidence of homelessness is not, in and of itself, sufficient to support a basic needs commitment, nor is evidence that a person has schizophrenia and has suffered discomfort or minor injuries as a result of delusions. See, *State v. Baxter*, 138 Or.App. 94, 906 P.2d 849 (1995).

**2. The Fiscal Note's determination that HB 16 will not dramatically increase the commitments at the Montana State Hospital is supported by third-party research of hospitalization rates at states that have broadened their commitment laws.**

House Bill 16's Fiscal Note estimates that expanding the Emergency Detention standards would add three emergency detentions per week for a total of 156 emergency detentions per year. That increase in emergency detentions would cost the state between \$75,300 and \$77,576 per year which would be offset by between \$139,282 and \$143,492 in annual payments from the counties. This estimated expenditure is higher than the fiscal note for a similar bill in the 2011 Legislature which estimated expanding the Emergency Detention Standards would cost the state between \$61,780 and \$64,276 per year. The difference in this estimate appears to be that the current Fiscal Note expects to keep all Emergency Detentions for four days, where the previous Fiscal Note expected to keep them for three days.

The additional of three emergency detentions per week is not a large increase for a hospital licensed for 189 beds. The Fiscal Note's assumption that broadening the Emergency Detention Criteria would have minimal impact on the number of commitments to the state hospital is supported by Dr. Robert Miller's study "Need-for-Treatment Criteria for Involuntary Civil Commitment: Impact in Practice."<sup>1</sup> Dr. Miller analysis reveals that North Carolina, Alaska, Kansas, Texas and Colorado actually decreased their inpatient admissions while expanding their civil commitment criteria.<sup>2</sup> Dr. Miller points out that if "the goals of early intervention are realized, there should ultimately be a lowering of hospital census figures because of shorter stays."<sup>3</sup>

The new standards may also open up additional savings. The process of getting 156 people who are in mental illness crisis into treatment will likely be other savings throughout the system. For instance, a number of the offenders on the State's forensic unit may have qualified for an expanded emergency detention before they committed their offense. If even one offender is prevented from committing a felony crime that would lead them to spend a year in the Montana State Hospital, that savings could free up enough bed days to pay for the program. (\$507.29 per day x 365 days in a year = \$185,160.85)

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<sup>1</sup> Robert D. Miller, M.D., Ph.D., "Need-for-Treatment Criteria for Involuntary Civil Commitment: Impact in Practice," *Am. J. Psychiatry* 1992; 149: 1380-1384.

<sup>2</sup> *Id.* at 1383.

<sup>3</sup> *Id.*

# Need-for-Treatment Criteria for Involuntary Civil Commitment: Impact in Practice

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*There has been considerable discussion in the literature on the differences between criteria for involuntary commitment that are based on dangerousness and criteria based on need for treatment. A number of states have adopted clinical criteria, and other state legislatures are actively considering them. Some libertarians argue that dangerousness is constitutionally required if a person is to undergo the loss of liberty involved in commitment. Citing widely publicized data from the state of Washington, they predict that a return to clinical criteria would result in a deluge of inappropriate commitments. Some clinicians counter that use of clinical criteria would result in selection of a much more appropriate clinical population and point to research indicating that strict observation of the need-for-treatment provisions of the APA model commitment statute would actually decrease the number of commitments. The author examines state hospital admission and census data from eight states that added need-for-treatment criteria to their commitment codes between 1975 and 1990 and argues that the data indicate that there is little reason to believe that such changes would result in the deluge of admissions predicted by the critics.*

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(Am J Psychiatry 1992; 149:1380-1384)

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In the 1970s a series of court decisions, starting with *Lessard v. Schmidt* (1), struck down the existing need-for-treatment criteria for civil commitment as being too broad and too vague. The Hawaii federal district court went so far as to opine that the diagnosis and treatment of mental illness are not acceptable as the basis for commitment because too much is left to subjective choices by individuals who are less than neutral (2).

As a result of such decisions, every state in the country eventually passed statutes making dangerousness to self or to others a requirement for involuntary hospitalization. Many libertarians have concluded that the court decisions indicated that dangerousness was constitutionally required before patients could be deprived of their liberty (3), even though the U.S. Supreme Court has avoided ruling definitively on the issue. In fact, the Court has three times indirectly supported the state's legitimate *parens patriae* interests in providing treatment for those mentally ill who are unable to accept needed treatment because of their illness. In *Jackson v. Indiana* (4), a 1972 case dealing specifically with commitment of persons found incompetent to stand trial, the Court held that "the States have traditionally exer-

cised broad power to commit persons found to be mentally ill . . . . The particular fashion in which the power is exercised . . . reflects different combinations of distinct bases for commitment sought to be vindicated. The bases that have been articulated include dangerousness to self, dangerousness to others, and the need for care or treatment or training."

In *O'Connor v. Donaldson* (5), the Court held that "the state cannot constitutionally confine, *without more*, a nondangerous person who is capable of surviving safely in freedom" (emphasis added); the phrase "without more" has generally been interpreted to mean treatment, consistent with the view that provision of effective and needed treatment would be sufficient to justify involuntary hospitalization. Four years later, in *Addington v. Texas* (6), the Court stated, even more directly, that "the state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves."

It is true that in its recent decision in *Zinerman v. Burch* (7), the Court, in dicta, cited its previous holding in *O'Connor* but omitted the key phrase "without more," thus again raising questions about its view on commitment for treatment. However, in view of the Court's increasingly clear position in favor of permitting states to set up their own individual procedures to govern admission to their institutions by narrowing the category of legitimate federal constitutional issues, the dicta certainly do not preempt debate on the issue.

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Appelbaum (8), writing before the *Burch* decision, concluded that need-for-treatment criteria were not inherently unconstitutional; rather, the statutes struck down by state and federal district courts had been impermissibly vague and/or overly broad. The situation is similar legally to the Supreme Court's rulings striking down state death penalty statutes in the early 1970s; the Court did *not* rule that capital punishment was unconstitutional but rather that the existing statutes were too vague (9). When more tightly drafted statutes were passed, the Court upheld them (10). A similar process may well occur in the case of civil commitment criteria based on need for treatment.

Over the past decade, following the failure of deinstitutionalization, there has been growing criticism of the dangerousness standard as inadequate to deal with the problems of the chronically mentally ill in the community. Critics have pointed out not only that the criterion of dangerousness selects the wrong types of patients (11) but that restrictive civil commitment criteria (12-14) and economic pressures (15) have led to diversion of mentally disordered persons from the civil to the criminal justice system, where they receive even less care than they did in the civil hospitals from which they were "decarcerated" (16) and are thus released back to the streets in the same condition in which they were arrested.

On the basis of a need-for-treatment model first proposed by Stone (17) and subsequently developed by Roth (18), APA accepted as its official policy some guidelines for statutes governing involuntary hospitalization that provided for commitment based on need for treatment under a guardianship model carefully constructed to prevent the abuses of the previous vague statutes struck down in the 1970s (19). Need for treatment is considered necessary, but not sufficient, for hospitalization. The APA model statute permits commitment either according to the usual criteria of danger to self or others or to prevent substantial physical or mental deterioration. There is also a requirement that the patient be incapable of consenting to either hospitalization or treatment.

The proposed statute drew criticism from libertarians (20) and support from some patient advocacy groups (21) and clinicians (22, 23), but the debate continued to be theoretical and ideological rather than empirically based. Opponents of need-for-treatment criteria feared that the clock would be turned back to the days of unfettered clinical decision making, when more than half a million patients were hospitalized involuntarily. To attempt to answer the question of the impact of need-for-treatment criteria, two research groups tried to estimate those effects by asking emergency room clinicians responsible for commitment evaluations according to existing dangerousness criteria to evaluate the same patients simultaneously according to the APA criteria (24-26). They reported that only 36%-56% of patients committable according to the dangerousness criteria would have been committable according to the need-for-treatment criteria, whereas the great majority of patients committable according to the need-for-treat-

ment criteria would also have been committable according to the dangerousness criteria. Such studies cannot, of course, substitute for empirical research into actual changes in admission patterns following changes in commitment criteria.

While no state has adopted the APA criteria in toto, a number of states have changed their statutes to permit commitment in order to prevent other than purely physical deterioration. After a highly publicized double murder by a mentally ill person who had been refused voluntary admission to a state psychiatric facility, the Washington state legislature revised its standard for the gravely disabled to permit commitment of a mentally ill person who "manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety" (27). Following this "horror story" there was nearly a doubling in state hospital admissions over the period of a year, beginning several months *before* the statute went into effect. The increase was attributed by Durham and various colleagues, in a series of articles, chiefly to the broadening of the commitment criteria (28). Their conclusion has been cited again and again when legislatures in other states have considered need-for-treatment criteria, while little has been published concerning even broader criteria in a number of other states.

After the previous need-for-treatment criteria were replaced by dangerousness standards, there were published studies that documented changes in admissions and census at state mental hospitals. With the exception of the Durham articles, there have been no attempts in the psychiatric literature to investigate changes following the reintroduction of need-for-treatment criteria for commitment. This article reports gross data from eight other states.

#### RESULTS OF CHANGES TO NEED-FOR-TREATMENT CRITERIA

There have in fact been significant changes in commitment statutes in a number of states besides Washington over the past 16 years. Table 1 shows state hospital admissions in these states before and after changes in their statutes. Since different states provided different types of information, total admissions are reported for four states and involuntary admissions for the remaining three.

In 1975 South Carolina passed a statute providing for commitment of patients who need hospital treatment and because of their condition lack sufficient insight or capacity to make responsible decisions with respect to their admission to a hospital (29). While involuntary admissions rose 14% in the year after the changes (table 1), voluntary admissions rose 51% during the same year, indicating that factors other than the new statutory criteria were the major reasons for a rise in admissions.

TABLE 1. State Hospital Admissions After Statutory Changes in Criteria for Involuntary Civil Commitment<sup>a</sup>

State	Admissions						
	2 Years Before New Statute (N)	1 Year Before New Statute		1 Year After New Statute		2 Years After New Statute	
		N	% Change	N	% Change	N	% Change
South Carolina <sup>b</sup>	2,920	2,786	-5	3,184	14	3,495	10
North Carolina <sup>c</sup>	12,101	11,425	-6	11,014	-4	8,104	-26
Alaska <sup>c</sup>	1,060	1,146	8	1,138	-0.1	1,056	-7
Hawaii <sup>c</sup>	291	279	-4	327	17	424	30
Kansas <sup>c</sup>	3,990	4,559	14	4,273	-6	4,163	-2
Texas <sup>b</sup>	11,773	12,722	8	12,323	-3	12,753	3
Colorado <sup>b</sup>	1,520	1,607	6	1,426	-11		

<sup>a</sup>Data were supplied by an official of each state's mental health department.<sup>b</sup>Involuntary admissions.<sup>c</sup>All admissions.

North Carolina revised its statutes in 1981 to permit hospitalization of persons who are unable to care for themselves, as sufficiently demonstrated by their engaging in grossly emotional or inappropriate behavior or displaying other signs of severely impaired insight and judgment (30). Following the change, both admissions and average census at the state's four mental hospitals, which receive approximately 80% of involuntary admissions, actually decreased. The data on North Carolina in table 1 demonstrate consistent decreases in admissions following the broadening of the commitment criteria.

In addition to the changes in criteria for involuntary hospitalization, North Carolina broadened its criteria for initial commitment to outpatient treatment. This was done to permit commitment of a person who is capable of surviving in the community but (on the basis of previous history) needs treatment to prevent further disability or deterioration that would predictably result in dangerousness and whose mental status negates his or her ability to make an informed decision to seek or comply with recommended treatment (31). The state provided capitation grants of \$2,000 per patient to community mental health centers to encourage the use of the new provision. Despite the broader criteria and financial incentives, Hiday and Scheid-Cook (32) reported that only 8.3% of initial commitments were to outpatient treatment.

Alaska revised its statutes, effective in 1985, to provide for hospitalization of a person who, as a result of mental illness, will, if not treated, suffer distress that impairs judgment, reason, or behavior, causing a substantial deterioration of the person's ability to function independently (33). There had been a mild (8%) rise in admissions to the state mental hospital the year before the changes, but after the changes, admissions fell consistently (table 1).

Hawaii revised its statutes in 1986 to provide for commitment of persons who are "obviously ill," defined as a "condition in which a person's current behavior and previous history of mental illness, if known, indicate a disabling mental illness, and the person is incapable of understanding that there are serious and

highly probable risks to health and safety involved in refusing treatment" (34). There was a significant rise in both new admissions and readmissions (table 1); however, the new statutory provisions have rarely been used because of constitutional questions.

Kansas also revised its statutes in 1986, to provide for commitment of patients who suffer severe mental disorders to the extent that they need treatment, lack the capacity to make informed decisions concerning treatment, and are likely to cause harm to themselves or others. "Likely to cause harm" means that the person is "likely, in the reasonably foreseeable future, to cause substantial physical injury or abuse to self or others, or substantial damage to another's property, as evidenced by behavior causing, attempting or threatening such injury, abuse or damage; or is substantially unable to provide for all of the person's basic needs, such as food, clothing, shelter, health or safety, causing substantial deterioration of the person's ability to function on the person's own" (35). After a rise in admissions before the changes in the statutes, both admissions and census fell after the changes (table 1).

Texas revised its statutes in 1987 to provide for hospitalization of persons who, as a result of mental illness, will, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress, will continue to experience deterioration of ability to function independently, and are unable to make rational and informed decisions about whether to submit to treatment (36). There was an 8% rise in involuntary admissions the year before the changes, which subsequently leveled out (table 1). Voluntary admissions did not fall after the new statute went into effect.

Colorado revised its statutes in 1989 to provide for hospitalization of persons who suffer from chronic mental disorders with psychotic features, who have been hospitalized at least twice within the previous 36 months, and who exhibit a deteriorating course (37). There was a rise in admissions the year before the changes, with a fall in the year after the changes (table 1).

Arizona passed a statute in 1990 that provides for commitment of persons who suffer from "permanent or acute disability" (38). The constitutionality of this stat-

ute has been challenged. A state court of appeals ruled in 1991 that the statute is not too broad because it requires the clear and convincing showing of a severe mental disorder that has a substantial probability of causing severe mental, emotional, or physical harm; it is not too vague because no warning is required for those incompetent to make treatment decisions and because courts are required to make factual findings of a mental disorder with a substantial probability of causing serious injury (39). The ruling was not appealed to the state Supreme Court, but another challenge is currently before a different appeals court. The new provision has been rarely used because many continue to fear that the criterion is unconstitutional. In the 12 months before the new law went into effect, there were 441 involuntary civil admissions to the Arizona State Hospital, while in the subsequent 8 1/2 months, there were 423. If it is found that this trend continued for the rest of the 12-month period, it would represent a 35% increase in admissions; however, patients committed under the new provision do not make up a significant percentage of the new admissions (personal communication, Dr. J. Migliaro, Arizona State Hospital).

## DISCUSSION

Since need-for-treatment criteria have been proposed by APA, and passed by the states I have listed, as additions to existing dangerousness criteria rather than as replacements, some initial increase in admissions after passage of such legislation would certainly be expected. After all, if no new patients were to be admitted, there would be no purpose for the legislation. Proponents of need-for-treatment criteria argue that since a major goal of the legislation is to permit early intervention and to provide effective treatment *before* patients deteriorate sufficiently to satisfy the dangerousness requirements, many of the patients committed under this standard would be committed eventually under existing criteria, and at that time they would require more lengthy hospitalization because of the increased severity of their condition.

With the exception of Washington State, the dire predictions by critics of need-for-treatment standards have not been borne out in practice since the passage of such legislation, despite the fact that no state has yet incorporated the protections proposed by APA in its model statute. This fact illustrates the multidetermined nature of admissions to psychiatric facilities (40).

Broader statutory criteria for commitment are most frequently enacted in a jurisdiction in response to specific circumstances that appear to call for a lower commitment threshold, such as publicized horror stories involving mental patients. In such situations, it is not uncommon for commitment rates to rise even without statutory changes (41), as in fact happened in the state of Washington, as well as in Alaska, Kansas, Texas, and Colorado in the year before their broadened criteria went into effect. Therefore, any observed increases

in commitments may be due as much to the social pressures leading to statutory changes as to the changes themselves.

North Carolina, Alaska, Kansas, Texas, and Colorado passed need-for-treatment criteria for commitment, and all experienced decreases in admissions. In Hawaii and Arizona, rates of admission to state hospitals rose contemporaneously with passage of broader commitment criteria, although data from those state hospitals indicated that very few commitments were made under the new criteria, again supporting the conclusion that both changes in commitment laws and rises in admissions may be due to the same underlying social pressures, rather than the conclusion that broadening the commitment criteria was responsible for the rises in admissions. The moderate rise in involuntary admissions following statutory changes in South Carolina was far overshadowed by an almost fourfold greater concurrent increase in voluntary admissions, which could not be attributed to statutory changes.

From the data presented here, it appears that opposition to broadening commitment criteria on the grounds that existing psychiatric facilities would be overwhelmed (as has been argued recently in the debate in the Wisconsin legislature) is misplaced. Concern about the use of costly inpatient resources, often at the expense of funding for community treatment programs, is certainly appropriate; but such concern should be raised on the basis of any social pressure for increased protection from the mentally ill, not just when statutory changes are proposed. In fact, the proposals themselves may be the best indication of such social pressure. And long-term effects need to be taken into consideration; if the goals of early intervention are realized, there should ultimately be a lowering of hospital census figures because of shorter stays.

It also appears that no broadening of commitment criteria should be enacted without specific attention to the resources that might be required for providing treatment. This was not done in Washington (even with the evidence of significant increases in admissions before the statute went into effect) and caused severe problems in service delivery at one state psychiatric hospital. In contrast, by proactively providing additional funding to outpatient facilities, North Carolina successfully anticipated potential problems stemming from passage of its broader outpatient commitment criteria.

Changes in admission and census rates are multidetermined (15, 40) and cannot be simplistically attributed to a single cause, such as changes in commitment criteria. Detailed studies are required, using interviews with knowledgeable persons involved in implementing changes and reviews of clinical and commitment documents, as well as before-and-after admissions and census data. In addition, such studies should be correlated with current events (as is routine practice in individual psychiatric interviews), and data from one jurisdiction should not be automatically accepted as applicable to another until differences in existing administrative and fiscal policies are factored in. When such comprehen-

sive projections are available, they should serve to provide decision makers with relevant information upon which to base their decisions concerning proposed statutory changes.

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